Connecticut Insurance Department

2003

# Legislative Summary

January Regular Session

Susan F. Cogswell
Commissioner

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*This document is an excerpted summary of relevant legislation. The summaries were taken from material prepared by the Office of Legislative Research. Please consult the actual legislative text in the public act for exact language.*

**Public Act No. 03-30** **House Bill No. 6376**

*An Act Concerning Minimum Valuation Standards*

**SUMMARY:** When adopting minimum valuation rules, this act requires the Insurance Commissioner to adopt and follow the valuation standards published in the latest version of the National Association of Insurance Commissioners' (NAIC) *Accounting Practices and Procedures Manual* and the NAIC's *Annual Statement Instruction Manual*, subject to modifications the Commissioner prescribes.

The act specifies that the accounting and minimum valuation standards the Commissioner must adopt and follow include the preamble, appendices, and actuarial guidelines of the practice and procedures manual.

EFFECTIVE DATE: October 1, 2003

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**Public Act No. 03-037** **Senate Bill No. 1**

*An Act Requiring Health Insurance Coverage For Craniofacial Disorders*

**SUMMARY:** This act requires certain individual and group health insurance policies to cover medically necessary orthodontic processes and appliances for treating craniofacial disorders in people age 18 and younger. These processes and appliances must be prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. Coverage is not required for cosmetic surgery.

The act applies to policies delivered, issued for delivery, amended, continued, or renewed in the state on or after October 1, 2003 that pay for (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) hospital or medical expenses, and (5) hospital and medical expenses covered by HMOs.

EFFECTIVE DATE: October 1, 2003

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**Public Act No. 03-49** **House Bill No. 6608**

*An Act Concerning Claims Made Pursuant To The Connecticut Insurance Guaranty Association*

**SUMMARY**: This act modifies the limitation on Connecticut Insurance Guaranty Association Act (CIGA) coverage for claims filed by nonresidents. Prior law required coverage for the claim of a nonresident claimant only if (1) the insured was a Connecticut resident, (2) the insolvent insurer was licensed to conduct business in Connecticut, and (3) the claimant's state of residence has an association similar to CIGA and that association refused the claim.

The act, instead, requires coverage for a nonresident claimant only if the insured was a Connecticut resident at the time the incident occurred and the insured had a net worth of $25 million or less when the policy was issued or any time after that. It defines net worth to include the aggregate net worth of the insured and all of its subsidiaries and calculated on a consolidated basis.

The act establishes a separate rule for workers' compensation. It requires coverage of a nonresident claimant's claim for workers' compensation benefits. The act also eliminates CIGA coverage for any claim by, or on behalf of, an affiliate of the insolvent insurer at the time the policy was issued or at the time of the insured event.

Finally, the act broadens the definition of an affiliate of an insolvent insurer by eliminating the December 31 of the year preceding the date the insurer became insolvent as the date to determine affiliation.

EFFECTIVE DATE: Upon passage (May 23, 2003) and applicable to claims filed on or after the act's effective date.

NONRESIDENT WORKERS' COMPENSATION CLAIMS
Under the act, CIGA is secondarily liable for coverage of a nonresident claimant's workers' compensation claim. The act requires the claimant to first seek recovery from the association operating in the claimant's state of residence before filing the claim against the CIGA.

**BACKGROUND**

*Connecticut Insurance Guaranty Association*

The association pays the valid property and casualty insurance claims of resident claimants if a member insurer becomes insolvent. The association assesses members to obtain funds for this purpose.

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**Public Act No. 03-50** **Senate Bill No. 922**

*An Act Concerning The Purchase Of Extended Warranty Contracts On Motor Vehicles*

**SUMMARY:** The act subjects motor vehicle extended warranty contracts to the statutory requirements for other types of extended warranties. It expands the definition of an extended warranty to contracts or agreements to (1) perform or provide indemnification for repair, replacement, or maintenance of a product instead of just for repair service and (2) cover operational or structural failure due to normal wear and tear in addition to defects in material, skill, or workmanship.

By law, an extended warranty provider is someone who issues, makes, provides, or offers to provide an extended warranty to a buyer. The act requires that a provider also be contractually

obligated to provide service under the extended warranty. Also by law, a retail seller of an extended warranty is excluded from the provider definition if it is the manufacturer of the covered product. The act expands this exclusion to include a subsidiary of the manufacturer.

EFFECTIVE DATE: July 1, 2003

**BACKGROUND**

*Requirements for Extended Warranty Contracts*

By law, among other things, an extended warranty contract must have (1) a clear description of the product; (2) a clear statement of when the contract begins and how long it lasts, covered and excluded parts and services, and any coverage limitations; (3) an explanation of the procedures the buyer must follow to obtain performance under the contract; and (4) a statement of the buyer's right to cancel the agreement. The extended warranty provider must also be insured under a reimbursement policy issued by an insurer authorized to do business in Connecticut and file a copy of its extended warranty form and reimbursement policy with the Insurance Commissioner.

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**Public Act No. 03-53** **House Bill No. 6378**

*An Act Concerning Minimum Nonforfeiture Provisions For Certain Annuities*

**SUMMARY:** This act replaces the 3% statutory guaranteed minimum interest rate used to calculate individual annuity nonforfeiture benefit amounts (paid-up annuity, cash surrender value, or reduced death benefit) with a formula that uses in part an indexed interest rate tied to the five-year Constant Maturity Treasury Rate reported by the Federal Reserve. The act phases in the indexed interest rate and applies it to annuity contracts issued on or after the act's effective date. It requires insurers who want to use the indexed rate between the act's effective date and July 1, 2005 to file a written notice with the Insurance Commissioner. Insurers that wish to continue using the current 3% interest rate can do so but all nonforfeiture benefit amounts for annuity contracts issued after July 1, 2005 must be determined by the new indexed interest rate.

The act permits, rather than requires, insurers to defer cash surrender benefit payments for up to six months and adds the requirement that they submit a written request to, and receive written approval from, the Insurance Commissioner before deferring such payments. The request must include an explanation of the deferral's necessity and equity.

The act expands the right of annuity holders to receive nonforfeiture benefits, changes the net consideration percentage used to define minimum nonforfeiture benefit amounts, increases the annual annuity contract charge, and requires the payment of interest on any unpaid annual annuity charge.

Finally, the act authorizes the Commissioner to (1) require certain evidence about the present value of any nonforfeiture benefit and (2) adopt implementing regulations.

EFFECTIVE DATE: Upon passage (May 23, 2003)

INDEX INTEREST RATE

The act requires the interest rate used to calculate the minimum nonforfeiture benefit amount to be based on the lesser of 3% or the five-year Constant Maturity Treasury Rate as reported by the Federal Reserve (as of a specific date or average over a period of time, rounded to the nearest 1/20 of 1%) less 125 basis points (1. 25%). This calculated interest rate cannot be less than 1%.

The act requires that the redetermination date, basis, and time period be stated in the contract. The indexed interest rate applies for an initial period of time and may be redetermined for additional periods. The act defines the "basis" as the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate used at each redetermination date.

If the annuity participates in an equity index benefit, the act authorizes an increase in the basis point reduction of up to 100 basis points (1%). It also requires, on the contract's issue or redetermination date, that the present value of the additional basis point reduction not exceed the market value of the benefit. And it authorizes the Commissioner to require insurers to demonstrate that the present value of the additional reduction does not exceed the benefit's market value. The Commissioner may disallow or limit the additional reduction if she determines that the evidence is not acceptable.

NONFORFEITURE BENEFIT

Prior law required annuity contracts to offer a paid-up annuity benefit to an annuity holder who stops making future premium payments. The act permits an annuity holder who submits a written request to receive this benefit as well.

NET CONSIDERATION PERCENTAGE

Prior law required the percentage of the net consideration for any given contract year used to define the minimum nonforfeiture amount to be 65% of the net consideration for the first year and 87. 5% for the second and subsequent years. The act changes the net consideration to 87. 5% of gross consideration credited to the contract during that year.

ANNUAL CHARGE WITH INTEREST

The act increases from, $30 to $50, the annual charge assessed on annuity contracts and subjects unpaid annual charges to the payment of interest calculated according to the indexed interest rate the act authorizes.

EVIDENCE OF PRESENT VALUE

The act prohibits the present value of the additional 100-basis point (1%) reduction on the contract issuance or redetermination date from exceeding the market value of the benefit.

IMPLEMENTING REGULATIONS
The act authorizes the Commissioner to adopt implementing regulations, including those (1) permitting increases in the additional basis point reduction, (2) providing for adjustments to the calculation of minimum nonforfeiture amounts for annuity contracts that participate in an equity index benefit and other contracts for which the Commissioner determines that adjustments are justified and (3) implementing any other provision of the act.

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**Public Act No. 03-55** **Senate Bill No. 1015**

*An Act Requiring Notice To Personal Risk Policyholders Regarding Services Provided By The Insurance Department*

**SUMMARY:** This act requires personal risk insurers or their designees who deny a claim to provide the insured with written notice of the denial. The last paragraph of the notice must include the following statement in at least 12-point type:

> IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY CONTACT THE DIVISION OF CONSUMER AFFAIRS WITHIN THE INSURANCE DEPARTMENT.

The notice must also include the address and toll-free telephone number for the department's Consumer Affairs Division and the department's Internet address.

Personal risk insurance is homeowner, tenant, private passenger automobile, mobile manufactured home, and other property and casualty insurance used to protect personal, family, or household needs.

EFFECTIVE DATE: January 1, 2004

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**Public Act No. 03-57** **Senate Bill No. 351**

*An Act Concerning Deficiencies In Insurance Claim Information*

**SUMMARY:** This act establishes the minimum information needed for a health care provider's claim for payment to be complete for processing under the law requiring timely payment of claims and not to be considered deficient. The claim must be submitted to an insurer on the standard Health Care Financing Administration (HCFA) 1500 or UB-92 form or their successor forms.

EFFECTIVE DATE: October 1, 2003

**BACKGROUND**

*Timely Payment and Unfair and Prohibited Insurance Practice*

The law requires insurers and other entities responsible for paying health care providers under an insurance policy to pay claims within 45 days after the claimant's insurer receives the proof of loss form or the health care provider's request for payment is filed according to the insurer's practice or procedure. When there is a deficiency in the information needed to process the claim, the insurer must (1) send written notice to the claimant or health care provider of all alleged deficiencies in information needed to process the claim within 30 days after the insurer receives a claim for payment or reimbursement, and (2) pay the claim within 30 days after the insurer receives the information requested.

Insurers and others that fail to pay claims in a timely manner must pay the claim plus 15% interest in addition to other penalties that may be imposed. The failure is also an unfair and deceptive act or practice in the business of insurance. The Insurance Commissioner, after notice and hearing, may (1) issue a cease and desist order, (2) order the payment of a monetary penalty of up to $1,000 for each act or practice or up to $10,000 for egregious acts or practices, (3) suspend or revoke a license, or (4) demand restitution.

*Related Bill*

sHB 6444 establishes an administrative appeal for health care providers aggrieved by a claim or reimbursement recoding. Recoding is changing health care service codes or group of codes by managed care organizations to lower the amount paid to providers.

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**Public Act No. 03-58** **Senate Bill No. 918**

*An Act Concerning Health Insurance Coverage For Inpatient Dental Care*

**SUMMARY:** The act requires certain individual and group health insurance policies to cover general anesthesia, nursing, and related hospital services provided to any patient, instead of just those under four. As under existing law, the service must be medically necessary and the patient must have a (1) complex dental condition that requires the procedure to be performed in a hospital or (2) developmental disability that places them at serious risk.

EFFECTIVE DATE: October 1, 2003

**BACKGROUND**

*Policies Affected*

The coverage mandate applies to individual and group health insurance policies that pay for (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4)

hospital or medical expenses, and (5) hospital and medical expenses paid by HMOs. The policy must be delivered, issued for delivery, renewed, or continued in Connecticut on or after October 1, 2003.

**Public Act No. 03-70** **House Bill 6442**

*An Act Concerning Health Insurance Coverage For Adopted Children*

**SUMMARY:** This act establishes an exception to the prohibition against certain policy provisions that affect insurance coverage for adopted children. It permits insurers, hospital or medical service corporations, or health care centers (HMOs) to evaluate the health (health underwriting) of an adopted child who is being added as a covered beneficiary under his adopted parent's health insurance plan if the required premium or subscription fee and completed application are not received by the insurer, hospital or medical service corporation, or HMO before the expiration of the 31-day period following the date the adopted child was accepted for coverage under the policy.

Under prior law, a legally adopted child could be added to his adoptive parent's individual or group health insurance policy and no preexisting condition, insurability, eligibility, or underwriting approval provision could be imposed on him if the insurer was given notice of the adoption and the parents paid any additional premium within 31 days of the insurer' acceptance of the adopted child.

EFFECTIVE DATE: October 1, 2003

POLICIES SUBJECT TO REQUIREMENT
The act applies to individual and group policies that pay for (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) accident expenses, (5) limited benefit expenses, (6) hospital or medical expenses, and (7) hospital and medical expenses paid by HMOs. The adopted child requirement applies to policies delivered, issued for delivery, amended, renewed, or continued in Connecticut on or after October 1, 2003.

**Public Act No. 03-77** **Senate Bill No. 4**

*An Act Concerning The Extension Of Group Health Insurance Benefits For Individuals Age Sixty-Two And Over*

**SUMMARY:** This act requires group health insurance plans to give people who terminate their employment, take a leave of absence, or reduce their hours because they become eligible to receive social security benefits an option to continue their coverage under the group plan. It requires this coverage to continue for the employee and his dependents until midnight of the day preceding his eligibility for Medicare. Prior law required only an 18-month extension for any

kind of employment termination, leave of absence, or reduction in hours. Under federal law, people can retire with a reduced social security benefit at age 62, but they are not eligible for Medicare until age 65, unless they are disabled.

This change does not apply to employers who self-insure their health benefits.

EFFECTIVE DATE: October 1, 2003

**BACKGROUND**

*Federal Social Security and Medicare Law*

Traditionally, people could receive (1) full social security benefits and Medicare at age 65 or (2) reduced benefits (but not Medicare) at age 62. A federal law pushed the age for receiving full benefits beyond 65 in a series of steps for people born after 1937. Those born in 1960 or later will be able to receive full social security benefits at age 67. But the federal law left the reduced benefits at age 62 and the Medicare eligibility age of 65 intact (42 U. S. C. § 416).

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**Public Act No. 03-78** **Senate Bill No. 71**

*An Act Concerning Medical Savings Account*

**SUMMARY:** This act exempts high-deductible individual and group policies used to establish federally qualified medical savings accounts (MSAs) from the $50 maximum home health care deductible required in certain health insurance policies. The exemption applies to policies that pay (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) accident-only expenses, (5) hospital or medical expenses, (6) limited benefit expenses, and (7) hospital and medical expenses covered by HMOs.

EFFECTIVE DATE: July 1, 2003

**BACKGROUND**

*Medical Savings Accounts*

The tax provisions of the 1996 federal Health Insurance Portability and Accountability Act (P. L. 104-191) authorized a four-year demonstration program beginning on January 1, 1997 that allowed up to 750,000 high-deductible health insurance policies to be sold to self-employed people and individuals employed at firms with up to 50 employees. The law mandated a series of cut-off dates for the MSA pilot program dependent on the number of accounts established at various times during the year. The pilot program was to end on October 1, 1999, if the number of MSA returns projected to be filed in 1999 exceeded 750,000. The Internal Revenue Service determined that only 44,784 MSA returns were projected to be filed for 1999, consequently the pilot program continues.

**Public Act No. 03-91** **Senate Bill No. 1112**

*An Act Concerning The Dram Shop Act*

**SUMMARY:** The Dram Shop Act makes someone who sells liquor to an intoxicated person liable if that person injures someone or property because of the intoxication. It does not require proof that the seller acted negligently. This act increases the maximum amount an injured person can recover under the act from $20,000 to $250,000 for injuries to a single person and from $50,000 to $250,000 in aggregate for injuries to more than one person.

The act eliminates an injured person's right to sue a seller for negligence in selling alcohol to someone at least age 21. The Connecticut Supreme Court recently established a common law (judge made) right for a person to file a negligence lawsuit against a seller

EFFECTIVE DATE: Upon passage (June 3, 2003)

**BACKGROUND**

*Dram Shop Act*

Under the Dram Shop Act, a liquor seller is liable if he or his employee sells liquor to an already-intoxicated person who injures a person or property. The actual amount of liability in a particular case is decided in court. The act requires the injured party to notify the seller within 60 days of the incident causing harm or his intention to sue for damages. Up to 120 days between the death or incapacity of the injured party and the appointment of an executor, administrator, conservator, or guardian of the estate is not counted toward the 60-day deadline. The notice must state (1) the time and day of the sale and to whom it was made; (2) the name and address of the injured party; and (3) the time, day, and place of injury. Suits must be brought within one year of the sale.

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**Public Act No. 104** **House Bill No. 6443**

*An Act Concerning The Confidentiality Of Certain Insurance Company Statements Filed With The Insurance Commissioner*

**SUMMARY:** This act expands the scope of confidential information filed with the Insurance Commissioner. It makes confidential and not available for public inspection any supplemental compensation exhibit or stockholder information in an annual statement prepared in accordance with the National Association of Insurance Commissioner Annual Statement Instructions if submitted to the Commissioner by a nonprofit insurer with fewer than 150 employees. The confidentiality requirement does not apply to exhibit or supplemental information about the insurer's three most highly compensated officers.

By law, insurance company, fraternal benefit society, and health care center financial analyses, financial examination work papers, and operating and financial condition reports prepared by, on behalf of, or for the use of the Insurance Commissioner or Insurance Department examiners are confidential unless (1) they are otherwise a matter of public record or (2) the Commissioner determines it is in the public interest to disclose or otherwise make them available for public inspection.

EFFECTIVE DATE: October 1, 2003

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**Public Act No. 03-119** **House Bill No. 5499**

*An Act Concerning Health Insurance Underwriting And Benefits And Disclosure Of Health Benefit And Claim Experience Data To Certain Bargaining Agents*

**SUMMARY:** This act prohibits, with one exception, insurers, fraternal benefit societies, hospital and medical service corporations, HMOs and other insurance-related entities that issue individual policies from (1) moving an insured from a standard to a substandard underwriting classification after the policy is issued or (2) increasing an insured's premium because of his claims experience or health status. The act authorizes an insurer to increase premium rates for an insured's classification only when the entire underwriting classification is subject to an increase because of its claim experience or health status as a whole.

The act broadens coverage for certain employees by requiring group policies offered by employers to satisfy 40 benefit requirements, instead of the 10 benefits required under prior law. The new benefit requirements apply to a covered employee group where 51% of the employees are employed in Connecticut.

Finally, the act requires insurers and third party administrators (TPAs) to provide the same health plan information the law already requires to exclusive bargaining agents of an employee group to exclusive bargaining agents of an employee subunit within an employee multi-bargaining group. It specifies that if the employees constitute a subunit of a multi-bargaining group, the insurer must provide their exclusive bargaining agents with the health plan information for either (1) the entire multi-bargaining unit, as it currently does or (2) the subunit within the multi-bargaining unit, at the request of the exclusive bargaining agent.

EFFECTIVE DATE: October 1, 2003

GROUP POLICIES

The act increases from 10 to 40 the number of mandated benefits that apply to group policies covering Connecticut employees under an employer-sponsored health insurance plan. The act applies to group policies that pay basic hospital, medical, and major medical expenses, which on or after October 1, 2003, are delivered, issued for delivery, renewed, or continued in another state where 51% of the employees covered under the policy are employed in Connecticut.

MANDATED BENEFIT COVERAGE UNDER GROUP POLICY

Prior law required coverage for 10 benefits denoted with an asterisk (*). The act requires coverage for the following additional 30 benefits:

1. preexisting medical condition
2. mental and nervous condition*
3. mentally or physically handicapped children
4. newborn infants*
5. early intervention services
6. accidental ingestion of a controlled drug*
7. hypodermic needles and syringes
8. cancer drugs
9. prescription foods
10. diabetes
11. home health care*
12. comprehensive rehabilitation services
13. occupational therapy
14. ambulance service*
15. emergency services and care
16. physician assistants and nurse practitioner services*
17. complications of alcoholism*
18. veterans
19. mammography*
20. people with breast cancer histories
21. direct access to OB GYNs
22. maternity and postpartum care
23. mastectomy of lymph node dissection
24. preventive pediatric care*
25. dependent and employee
26. tumors and leukemia and breast implant removal and reconstruction
27. chiropractic services
28. continuation, extension and conversion rights*
29. maternity benefit continuation
30. prospective adoptive children
31. prescription birth control
32. diabetes self-management training
33. lyme disease
34. prostate cancer screening
35. in-hospital dental services
36. ostomy
37. pain management
38. cancer clinical trials
39. colon cancer screening
40. hearing aids

**BACKGROUND**

*Underwriting Classification*

Underwriting classification refers to the factors insurers consider in rating an applicant for insurance. The standard underwriting classification considers the insured's age, gender, occupation, marital status and geographic location. A substandard underwriting classification may also consider an insured's claims experience or health status in developing a premium rate.

*Bargaining Agent*

By law, insurers or TPAs that provide insurance or administrative services must provide, at the request of the exclusive bargaining agent for an employee bargaining unit (1) a description of the health benefits the employer makes available, (2) the claims experience relating to such benefits, and (3) the cost to the employer for insurance or administrative services the insurer or TPA provides.

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**Public Act No. 03-121** **Senate Bill No. 836**

*An Act Concerning The Confidentiality Of Insurance Department Information*

**SUMMARY:** This act requires the Insurance Commissioner to maintain certain records as confidential if (1) they are protected from disclosure under federal or state law or (2) in her opinion, they would disclose, or would reasonably lead to the disclosure of, certain investigative, personal, financial, or medical information.

EFFECTIVE DATE: October 1, 2003

CONFIDENTIAL INFORMATION
The act requires the Commissioner to maintain as confidential (1) information obtained, collected, or prepared in connection with an examination, inspection, or investigation and (2) public complaints received by the Insurance Department. The act prohibits the disclosure of this information if federal law or state statute protects it. It also prohibits disclosure if, in the Commissioner's opinion, it would reveal or would reasonably lead to the disclosure of (1) investigative information that would prejudice an investigation, until the investigation is concluded or (2) personal, financial, or medical information about a person who has filed a complaint or inquiry with the Insurance Department, unless written consent is obtained first.

**Public Act No. 03-127** **House Bill No. 6377**

*An Act Concerning Financial Oversight of Insurers*

**SUMMARY:** This act authorizes the Insurance Commissioner to use the services of attorneys, actuaries, accountants, and other experts necessary to help her (1) conduct a financial analysis of an insurer, (2) review an insurer's license application, or (3) review transactions within an insurance holding company system domiciled in Connecticut. The use of outside experts is authorized only when they are not otherwise available on the Commissioner's staff. The act prohibits any outside attorney, actuary, accountant, or expert from performing the duties of any person employed by the Insurance Department on November 1, 2002. The domestic, out-of-state, or foreign insurer subject to the examination or review must pay the cost of these experts.

EFFECTIVE DATE: October 1, 2003

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**Public Act No. 03-149** **Senate Bill No. 353**

*An Act Expanding Coverage Under The State Employee Health Plan*

**SUMMARY:** This act adds employees of small employers to the list of employees for whom the Comptroller, with the Attorney General and the Insurance Commissioner's approval, is authorized to arrange group hospital, medical, and surgical health insurance under the state employee health plan.

The act requires (1) any coverage arranged for small employers to continue to be underwritten according to the small employer community rating law and (2) small employers to comply with the same state employee plan participation requirements that apply to employees of community action agencies, nonprofit corporations, and municipalities.

The act defines a "small employer" as any person, firm, corporation, limited liability company, partnership, or association actively engaged in business for at least three consecutive months that, on at least 50% of its working days during the preceding 12 months, employed no more than 50 employees, half of them employed in the state. A small employer includes a self-employed individual.

The act also makes minor changes with regard to insurance plan options and reporting requirements.

EFFECTIVE DATE: Upon passage (June 26, 2003)

STATE EMPLOYEE HEALTH INSURANCE PLAN

*Participation Requirements*

The act requires small employers to comply with the following requirements:
1. Participation in the plan must be voluntary.
2. Where an employee organization represents employees of a small employer, both parties must agree on participation and neither may submit the issue of participation to binding arbitration, where available, except by mutual agreement.
3. No group of employees may be denied participation because of past or future health care costs or claims experience.
4. Rates paid by the state for its employees may not be adversely affected, and the state cannot pay administrative costs to the plan.
5. Participation in an amount determined by the state must be for the plan's duration or such other period mutually agreed upon by the small employer and the Comptroller.

*Plan Options and Reporting*

The act expands the Comptroller's authority to arrange a plan that varies from the plan offered to state employees by including small employers and community action agencies and allows her to do so without having to obtain the Office of Policy and Management secretary's approval. She can already do this for municipal employees. The act also gives her the authority to offer standard or alternative plans, except small employer plans, on either a fully underwritten or risk pool basis. Under prior law, alternative plans had to be fully underwritten. Under the act, small employer plans must be offered on a fully underwritten basis.

Beginning February 1, 2004, the act adds nonprofit corporations, community action agencies, and small employers to the list of plans the Comptroller must review annually and submit a report to the General Assembly. It eliminates a requirement that the Comptroller review and report annually to the Insurance and Real Estate Committee on the plan arranged for employees of community action agencies.

**BACKGROUND**

*Small Employer Law*

Small employer plan premiums are based on a community rate, adjusted for age, gender, geographic area, industry, group size, and family composition. Rates cannot be based on the health status or claims experience of the small employer or its employees and their dependents.

*Community Action Agency*

The statutes define a "community action agency" as a public or private nonprofit agency previously designated by, and authorized to accept funds from, the federal Community Service Administration for community action agencies under the 1964 Economic Opportunity Act or a successor agency established under law.

**Public Act No. 03-152** **Senate Bill No. 916**

*An Act Concerning Viatical Settlements*

**SUMMARY**: This act strengthens the viatical settlement law and broadens its scope to regulate life insurance settlement transactions involving the sale of a life insurance policy's death benefit by healthy individuals to a purchaser. In such a transaction, the insured, or viator is the owner of the policy who enters into a viatical settlement contract for its sale or other disposition.

The act expands the licensing requirements applicable to viatical settlement providers ("provider") (people who enter into or arrange a viatical settlement contract) and viatical settlement brokers ("broker") (people who represent the viator and negotiate a contract between a viator and a provider for a fee), to include viatical settlement investment agents ("agent") (people appointed or contracted by a provider and who acts on the provider's behalf to solicit or arrange funding for a viatical settlement purchaser to invest in a viatical settlement). A viatical settlement purchaser ("purchaser") is a person who (1) gives a sum of money as consideration for a life insurance policy or interest in the death benefit, (2) owns or acquires beneficial interest in a trust that owns a viatical settlement contract, (3) or is a beneficiary of a policy that is the subject of a viatical settlement contract. The act applies to agents the same standards used to determine the qualifications for issuing a license to providers and brokers.

The act broadens the prohibition against using certain forms without satisfying filing and approval requirements and adds authority for the commissioner to disapprove them. It also broadens contractual rescission rights; adds exceptions to the prohibition against revealing a viator's personal identity; and expands disclosure obligations for providers, brokers, and agents. The act establishes advertising requirements, including content rules and restrictions when making viatical settlement offers to the public.

Finally, the act authorizes the Insurance Commissioner to adopt implementing regulations and establish bonding or other financial accountability requirements for providers and brokers. It also designates the Commissioner as agent for service of process for providers, brokers, or agents.

EFFECTIVE DATE: October 1, 2003

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**Public Act No. 03-169** **Senate Bill No. 917**

*An Act Concerning Preferred Provider Networks*

**SUMMARY:** This act revises the law regulating preferred provider networks (networks), requiring formal licensing by the Insurance Commissioner, instead of an annual informational filing. It modifies the definition of a network, limiting it to entities that pay claims for the delivery of health care services; accept the financial risk for the delivery of those services; and establish, operate, or maintain an arrangement or contract with health care providers relating to

(1) the health care services they provide and (2) the amount of compensation they receive for such services. Networks include health care services covered under a self-insured employee welfare benefit plan established under the federal Employee Retirement Income Security Act. They exclude managed care organizations (MCOs), workers' compensation preferred provider organizations, individual practice associations, and physician hospital associations whose primary function is to contract with insurers and provide services to providers.

The act establishes licensing procedures, expands the information networks must file with their application, and subjects networks to examination by the Commissioner. It establishes (1) minimum net worth, financial solvency, and other financial requirements for networks; (2) mandatory provisions in contracts between networks and MCOs; (3) certain contractual obligations that MCOs must satisfy in their arrangements with networks; (4) procedures for network enrollees to lodge complaints; and (5) protections for enrollees, employees, and providers who disclose information to the Commissioner about violations of the law.

The act also (1) prohibits MCOs contracting with networks and networks and their providers from seeking compensation from, or having any recourse against, network enrollees for the payment of benefits; (2) requires networks to follow existing utilization review procedures when deciding whether to approve certain health care services; (3) requires MCOs contracting with networks to file certain financial information with the Commissioner; and (4) specifies that MCOs contracting with networks are ultimately responsible for health care services.

Finally, the act extends to networks the Commissioner's enforcement authority over insurers and MCOs, requires her to investigate complaints referred from the managed care ombudsman, broadens her reporting responsibility to the Governor and General Assembly committees, and authorizes her to adopt implementing regulations.

EFFECTIVE DATE: October 1, 2003, except for the provisions on (1) licensing, (2) financial security and financial information filing, (3) MCO monitoring of network financial stability and management expertise, (4) contractual provisions between networks and MCOs, and (5) MCO information submittal to networks, which are effective May 1, 2004.

LICENSING REQUIREMENTS

The act prohibits (1) beginning May 1, 2004, networks from entering into or renewing any contractual relationship with a managed care organization unless the Commissioner licenses the network and (2) beginning May 1, 2005, any network from conducting business in this state unless it is licensed by the Commissioner.

To obtain or renew a license, the act requires networks to submit an application to the Commissioner on a form she prescribes and pay a $2,500 new or renewal license fee. The fee must be used solely to regulate networks. Applications must be submitted by March 1 annually to meet the May 1 issuance or renewal date. The application must include most of the same information networks previously filed with the Commissioner, as well as the following new items of information:

1. the identity of the network and the name and business address of a contact person of the company or organization controlling the network's operations;
2. a description of the controlling company or organization;
3. a certificate of good standing from the secretary of the state regarding an in- or out-of-state network or controlling company or organization;
4. a copy of the network's and controlling company's or organization's financial statement and audited financial report for the most recently concluded fiscal year, and the name and address of the accounting firm or internal accountant that prepared the statement;
5. the names, official positions, and occupations of members of the network or controlling company or organization's board of directors or other policymaking body, their owners and executive officers responsible for the network, company or organization's activities regarding the health care service network;
6. a report of any suspension, sanction, or other disciplinary action relating to an in- or out-of-state network, controlling company, or organization;
7. the identity, address, and current relationship of any related or predecessor controlling company or organization where a substantial number of the board or policymaking body members, executive officers, or principal owners of both companies are the same;
8. a list of all entities on whose behalf the network has contracts or agreements to provide health care services and a table listing all major categories of health care services the networks provides;
9. the approximate number of all enrollees served under network contracts or agreements, a list of the network's subcontractors that assume financial risk, and the extent to which each assumes such risk, excluding individual providers;
10. a contingency plan describing how health care services will be provided in the event of insolvency;
11. the geographic area and the names of the hospitals included in the network's plan of operation;
12. the number of primary care and specialty care doctors and other contracting providers and the percentage of each group's capacity to accept new patients; and
13. any other information the Commissioner requests.

EXAMINATION

Under the act, networks must allow the Commissioner to inspect their books and records and to examine, under oath, any network officer or agent and any company or organization that controls the network about the use of network, controlling company, or organization funds and compliance with (1) the act's financial accountability provisions and (2) the terms and conditions of its contract to provide health care services. Networks must notify the Commissioner of any material modification of any matter or documents furnished or filed under the act and include any supporting documents necessary to explain the modification.

NET WORTH AND FINANCIAL SOLVENCY REQUIREMENTS

The act requires networks to maintain a minimum net worth of either (1) the greater of (a) $250,000, or (b) an amount equal to 8% of its annual expenditures as reported on its most recent completed financial statement filed with the Commissioner or (2) another amount the Commissioner determines.

The act requires networks and MCOs that contract with networks to post, maintain, or arrange for a letter of credit, bond, surety, reinsurance, reserve, or other financial security acceptable to the Commissioner to pay any outstanding debt they owe network providers in the event of insolvency or nonpayment. Networks must maintain the security in an amount at least equal to the greater of (1) an amount calculated on the basis of the two quarters within the past year with the greatest amounts the network owed to participating providers, (2) the actual outstanding debt owed providers, or (3) another amount determined by the Commissioner. The amount may be credited against the network's minimum net worth requirement, and the Commissioner must review the amount and the calculation on a quarterly basis.

MCOs must post or maintain the security or require the network to post or maintain it. The amount is calculated in the same manner as for networks. In the event of insolvency or nonpayment, the network or another entity designated by the Commissioner must use the security to pay any outstanding debt owed providers. Any remaining balance may be used to reimburse the MCO for payments it may have made to providers on behalf of the network.

The act also requires MCOs, when they enter into a contract with a network and annually thereafter, to provide the network with the following information: (1) the amount and method it will use to compensate network providers; (2) how it will inform the network about any financial risk the network assumes under the contract, including information about enrollment data, primary care provider-to-covered person ratios, provider-to-covered person ratios by specialty, services the network is responsible for, expected or projected utilization rates, and factors used to adjust payments or identify risk-sharing targets; (3) the annual statement for MCOs that the National Association of Insurance Commissioners' prepares; and (4) any other information the Commissioner may require.

The act requires networks to examine the outstanding debt they owe providers each quarter. If they determine that the amount exceeds 95% of the security required under the act, they must mail notice to each participating provider about the status of incurred claims and send notice to each MCO with which they contract and the Commissioner on a form she prescribes. The Commissioner must meet with the MCOs and the networks to ensure continued services to enrollees and payment to providers.

MANDATORY CONTRACT PROVISIONS

The act requires MCOs to ensure that any contract they enter into with a network includes the following provisions:

1. At the time a contract is entered into, and annually thereafter, the network must provide the MCO, at the MCO's request, with a complete and audited financial statement; an accurate list of providers; and documentation, satisfactory to the MCO, that the network has (a) sufficient ability to accept financial risk; (b) appropriate management expertise and infrastructure; (c) an adequate provider network, taking into account the geographic distribution of enrollees and providers and whether the providers will accept new patients; and (d) the network's ability to ensure the delivery of health care services as required under the contract.
2. Networks must provide the MCO with quarterly status reports that include (a) updated financial statement information; (b) a report showing the amount paid providers; (c) an estimate

of payments due providers but not yet reported; (d) amounts owed providers for that quarter; and (e) the number of utilization review determinations not to certify an admission, service, procedure, or extension of a hospital stay made by or on behalf of the network and the outcome of any determination appeal.
3. Networks must notify the MCO no later than five business days after (a) any change in its ownership structure; (b) concerns about its financial or operational viability are raised; or (c) the loss of its license in this or another state.
4. If the network fails to pay for health care services, enrollees are not be liable to providers or the MCO for any amount owed by either the network or MCO because of the MCO's nonpayment, insolvency or breach of contract between the MCO, and the network and that such payments may be made or reimbursed from the security posted and maintained.
5. Networks must include in all contracts between themselves and providers a provision that if the network fails to pay for health care services for any reason, enrollees are not liable to providers or the network for any sums owed by either the network or MCO because of nonpayment by, or insolvency of, the MCO or breach of contract between the MCO and the network.
6. Networks must provide information, satisfactory to the MCO, about its reserves for financial risk.
7. MCOs must maintain or require the network to maintain a letter of credit, bond, surety, reinsurance, or other financial security acceptable to the Commissioner, in order to satisfy the risk accepted by the network. This security must be in an amount at least equal to the greater of (a) an amount calculated on the basis of the two quarters in the past year with the greatest amounts owed by the network to participating providers, (b) the actual outstanding amount owed providers, or (c) another amount determined by the Commissioner. In the event of insolvency or nonpayment, the security must be used by the network or other entity designated by the Commissioner for paying any outstanding debt owed providers.
8. The MCO may pay providers directly in the event of insolvency or mismanagement by the network (payments may be made or reimbursed from the security posted).
9. In the event of a network becoming insolvent, otherwise ceasing to conduct business, as determined by the Commissioner, or demonstrating a pattern of nonpayment of authorized claims, as determined by the Commissioner, for a period greater than 90 days, the MCO may transfer or assign contracts between the network and providers to the MCO for future services.
10. Contracts between a network and providers must include a provision transferring and assigning the contract to the MCO for the delivery of future health care services to enrollees in the event of a network becoming insolvent, otherwise ceasing to conduct business, as determined by the Commissioner, or demonstrating a pattern of nonpayment of authorized claims, as determined by the Commissioner, for a period greater than 90 days.
11. Networks must pay for the delivery of health care services and operate or maintain contracts with providers in a manner consistent with the law that applies to MCO's contracts with enrollees and providers.
12. Networks must ensure that utilization review determinations are made in accordance with state law, except that initial appeals of a determination not to certify an admission, service, procedure, or extension of a hospital stay must be reviewed by a practitioner in a specialty related to the condition that is the subject of the appeal, and in cases where an appeal to reverse a determination not to certify is unsuccessful, the network must refer the case to the MCO, which

must conduct the subsequent appeal using a practitioner in a specialty related to the condition that is the subject of the appeal (see below).
13. Contracts between networks and providers must contain a provision that specifies that if the network fails to pay for health care services as required under the contract, enrollees are not liable to providers for any amount owed them or any amount owed by the MCO because of nonpayment, insolvency, or breach of contract between the MCO and the network.

UTILIZATION REVIEW DETERMINATIONS
The act requires any utilization review determination made by or on behalf of a network to be made according to state law, except that any initial appeal of a determination not to certify an admission, service, procedure, or extension of a hospital stay must be conducted by a practitioner in a specialty related to the condition that is the subject of the appeal. Any subsequent appeal to the MCO on whose behalf the network provides service must also be conducted by a practitioner in a specialty related to the condition that is the subject of the appeal.

ENROLLEE HOLD-HARMLESS
The act prohibits, under any circumstance, including an MCO's nonpayment, insolvency, or breach of contract with a network, a network from (1) billing; (2) charging; (3) collecting a deposit from; (4) seeking compensation, remuneration, or reimbursement from; or (6) having any recourse against an enrollee or his designee, other than the MCO, for covered benefits provided. The prohibition does not include the copayments, deductibles, or other out-of-pocket expenses the enrollee is required to pay under the managed care plan.

MCO'S CONTRACTUAL OVERSIGHT OBLIGATIONS
The act requires MCOs that contract with networks to:
1. have adequate procedures in place to notify the Commissioner, no later than five days after discovery, that a network has experienced an event that may threaten its ability to materially perform its contractual obligations;
2. monitor and maintain systems and controls for monitoring the financial health of a network with which it contracts;
3. provide the Commissioner with an annually updated contingency plan describing how health care services will be provided to enrollees in the event of the network's insolvency or mismanagement, including a description of what contractual and financial steps have been taken to ensure continuity of care;
4. verify the information in the quarterly status report submitted by the network and submit such information to the Commissioner, on a form she prescribes, no later than 10 days after receiving her request for such information;
5. demonstrate to the Commissioner's satisfaction that it can fulfill its obligation to provide health care services to enrollees in the event of the failure of a network, for any reason;
6. annually certify to the Commissioner, on a form she prescribes, that the MCO has reviewed the documentation submitted by the network and determined that the network maintains an adequate number of providers to ensure the delivery of health care services as required under the contract, and if the Commissioner determines that the certification was not submitted in good faith, she may deem the MCO as having not complied with the requirement take corrective action; and

7. provide coverage, in the event of a network failure, for the enrollee to continue treatment with the treating provider under the network contract regardless of whether the provider participates in the MCO's plan. Such until the earlier of (1) the date the enrollee's treatment is completed under an authorized treatment plan in effect on the date of failure or (2) the date the contract between the enrollee and the MCO terminates. The act specifies that a MCO must compensate the provider for such continued treatment at the rate due the provider under his contract with the failed network.

The act specifies that MCOs must remain fully responsible under the managed care plan and applicable state or federal law for providing health care services to its enrollees. It requires MCOs to exercise due diligence in their selection and oversight of a network.

The act specifies that if a MCO determines that the number of network providers is inadequate and must be increased, the MCO must give the Commissioner written notice of its determination. The notice must describe (1) any plan in place for the network to increase its provider network and (2) the MCO's contingency plan in the event the network does not satisfactorily increase its providers.

Networks are not required to share with the MCO with which they contract proprietary information about their contractual arrangement with providers who are not part of its network and other networks and MCOs.

ACCESS TO CARE

The act prohibits a network under contract with a MCO to provide health care services to enrollees from establishing terms, conditions, or requirements for access, diagnosis, or treatment that are different than the terms, conditions, or requirements for access, diagnosis, or treatment under the MCO's plan. But, a network may not be required to provide an enrollee access to a provider who does not participate in its network unless required under its contract with the MCO. A network must pay for the delivery of health care services and operate and maintain arrangements or contracts with providers that are consistent with the law that applies to the MCO's contract with enrollees and providers.

COMPLAINT PROCEDURE

The act requires the Commissioner to receive and investigate any (1) grievance filed by an enrollee or his designee against a network, MCO, or both concerning matters governed by the preferred provider network statute, as amended by the act, and the utilization review and unfair insurance practice laws or (2) referrals from the Office of Managed Care Ombudsman. She must code, track, and review each grievance or referral, and the network, MCO, or both must provide her with all relevant information necessary for her to investigate the grievance or referral.

The Commissioner must maintain as confidential information she collects in the course of her investigation and may not disclose it except to the extent necessary to (1) ensure compliance with the preferred provider network statute, certain provisions of the act and the utilization review, or unfair insurance practices laws; (2) bring an enforcement action under current law; (3) inform the managed care ombudsman; or (4) disclose, as a public record, information concerning the nature of any grievance or referral and the Commissioner's final determination. The act

excludes personal information from disclosure under the public record disclosure requirement. The act requires the Commissioner to report to the managed care ombudsman resolutions of any matter he or she refers to her.

MANAGED CARE OMBUDSMAN'S DUTIES

The act expands the managed care ombudsman's authority to make referrals to the Commissioner if he or she finds that a network may have engaged in a pattern or practice that violates the preferred provider network, utilization review, or unfair insurance practice laws.

The act also requires the ombudsman and the Commissioner to jointly compile a list of complaints received against MCOs and networks and the Commissioner to maintain such list. It prohibits the disclosure of a complainant's name if it violates the whistleblower law or the confidentiality requirement the ombudsman must adhere to.

ENFORCEMENT AUTHORITY

The act specifies that if the Commissioner determines that a network, MCO, or both have failed to comply with the preferred provider network statute, certain provisions of the act and the utilization review or unfair insurance practice laws, she may bring the following enforcement actions: (1) issue a cease and desist operations order against the network, MCO, or both; (2) terminate or suspend a network's license; (3) institute a corrective action against the network, MCO, or both; (4) order the network, MCO, or both to pay a civil penalty up to $1,000 for each act or violation; (5) order the payment of reasonable expenses necessary to compensate the Commissioner for the cost of any investigation or enforcement action; and (6) use any existing enforcement authority to obtain compliance.

The act authorizes the Commissioner to hold a hearing on any matter governed by the preferred provider network statute, utilization review, or unfair insurance practices laws. It also authorizes the Commissioner, subject to the confidentiality and liability protections under existing law authorizing her to conduct insurance company examinations, to engage the services of attorneys, appraisers, independent actuaries, certified public accountants, or other professionals and specialists to assist her in conducting investigations. The MCO, network, or both must pay the cost for such professionals.

To ensure that covered benefits are provided, the act authorizes the Commissioner to assign or require the network to assign its rights and obligations under any contract with providers if it fails to comply with the preferred provider network statute, as amended by the act, or the utilization review and unfair insurance practice laws.

ANTI-RETALIATION PROVISION

The act prohibits health insurers, HMOs, utilization review companies, and networks from taking or threatening to take any adverse personnel or coverage-related action against any enrollee, provider, or employee in retaliation for (1) filing a complaint with the Commissioner or managed care ombudsman or (2) disclosing information to the Commissioner about a violation of the preferred provider utilization review, or unfair insurance practice laws, unless the disclosure violates the Connecticut Insurance Information and Privacy Protection Act or the federal Health Insurance Portability and Accountability Act of 1996 or regulations adopted under them. The act

authorizes an aggrieved enrollee, provider, or employee to bring a civil action in Superior Court to recover damages and attorney's fee and costs.

IMPLEMENTING REGULATIONS
The act authorizes the Commissioner to adopt implementing regulations, including those to implement provisions requiring (1) networks to provide certain forms of financial security and information, (2) MCO and network contract provisions, (3) enrollee hold-harmless provisions, (4) MCO contractual obligations, (5) enforcement authority, and (6) complaint procedures.

ANNUAL REPORTS
The act broadens the type of information the Commissioner must annually report to the Governor and the Insurance and Real Estate and Public Health committees. It adds the requirement that she provide a summary of her procedures and activities in conducting market conduct examinations of networks, including a description of complaints and violations involving networks that provide services to enrollees on behalf of MCOs.
It also broadens the type of information MCOs must report to the Commissioner. It requires each MCO to include in its quality assurance plan report to the Commissioner the number of utilization review determinations not to certify an admission, service, procedure, or extension of a hospital stay that are made by or on its behalf. The act requires each MCO to file with the commissioner (1) a model contract that contains the provisions currently in force in contracts between MCOs and networks, (2) a written statement of the types of financial arrangements or contractual provisions a MCO has with a network, and (3) the number and nature of participating preferred provider networks.

**BACKGROUND**

*Connecticut Insurance Information and Privacy Act*

The act establishes standards for the collection, use and disclosure of personal information obtained in connection with insurance transactions and gives to certain individuals specific rights with respect to the collection, use, or disclosure of personal information involving them.

*Health Insurance Portability and Accountability Act*

The federal law establishes basic patient privacy rights with respect to protected health information, including the right to: (1) receive a written notice of privacy practices from health insurance plans and covered providers; (2) access or request an amendment to health records; (3) receive an accounting of the instances where personal health information is disclosed for other than treatment, payment, or health care operations if authorization was not required to make the disclosure; and (4) inquire or make complaints to health care providers or plans regarding the privacy and confidentiality of health information.

**Public Act No. 03-199** **Senate Bill No. 837**

*An Act Concerning Minor And Technical Changes To The Insurance Statutes*

**SUMMARY:** This act makes several technical revisions and minor changes to the insurance statutes. It:

1. expands the definition of insurer by including a receiver of an insurer and any person, except a fraternal benefit society, doing any kind or form of insurance business, instead of just corporations, associations, and partnerships doing any kind or form of insurance business;
2. revises the annual electronic statement filing that insurers make with the National Association of Insurance Commissioners (NAIC) to (a) include any additional information prescribed by the Insurance Commissioner, (b) allow for future changes in filing format and scope, and (c) require filing of financial analyses and examination synopses with NAIC rather than NAIC's Insurance Regulatory Information System;
3. requires health care centers with capital stocks to obtain the Commissioner's approval, after notice and hearing, to amend their certificate of incorporation to change their name;
4. permits, rather than mandates, adoption of implementing regulations governing utilization review companies, managed care companies, and preferred provider networks;
5. clarifies that HMOs must offer to continue an insured's group coverage when coverage is lost under a master policy; and
6. revises the definition of a swap agreement under NAIC's model insurance insolvency law to include rate cap agreements, rate floor agreements, and rate collar agreements.

The act also deletes obsolete references, redundant language and obsolete date references.

EFFECTIVE DATE: October 1, 2003

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**Public Act No. 03-250** **House Bill No. 6546**

*An Act Concerning Vicarious Liability For Persons Renting Or Leasing Certain Motor Vehicles*

**SUMMARY:** By law, anyone who rents or leases a motor vehicle he owns to another person is liable for personal or property damage caused by the vehicle's operation to the same extent the operator would have been had he owned the vehicle.

This act exempts from this law people who lease private passenger vehicles to others, if the total lease term is for one year or more and the vehicle is insured for bodily injury liability for at least $100,000 per person and at least $300,000 per occurrence at the time the damages are incurred. This exemption applies to (1) private passenger cars; (2) station wagons; (3) campers; (4) truck-type vehicles with a gross vehicle weight of less than 10,000 pounds that are registered either as passenger cars, as passenger and commercial vehicles, or used for farming purposes; and (5) commercially registered vehicles as defined by law. The act specifically excludes from this exemption (1) motorcycles and (2) a motor vehicle used as a public or livery conveyance.

The act also exempts from liability people who rent to others trucks, tractor trailers and tractor trailer units with a gross vehicle weight of 10,000 pounds or more if (1) the lease or applicable contract term is for one year or more and (2) the loss or claim is insured by any combination of coverage, through an insurer, for at least $2 million.

The act exempts from double or treble damages the owner of a rental or leased motor vehicle who was not operating the vehicle when the damages occurred. By law, a court can award double or treble damages if an injured party has pleaded that another party has deliberately or recklessly operated a motor vehicle in any of the following ways, and that such a violation was a substantial factor in causing injury, death, or property damage: (1) traveling unreasonably fast, (2) speeding, (3) driving recklessly, (4) operating under the influence of drugs or liquor or while having an elevated blood alcohol content, (5) illegally driving in the wrong lane, (6) passing in a no-passing zone, (7) illegally driving across a highway dividing strip, (8) driving the wrong way on a one-way street or rotary, or (9) failing to drive a reasonable distance apart.

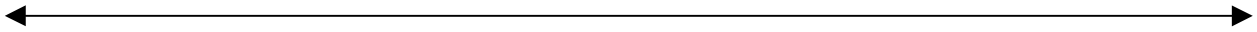
The act applies to causes of action that arise on or after October 1, 2003.

EFFECTIVE DATE: October 1, 2003

**BACKGROUND**

*Insurance Coverage*

To register a motor vehicle in Connecticut, an owner must have proof of financial responsibility to satisfy claims for damages of $20,000 for a single personal injury or death, $40,000 for more than one personal injury or death occurring in one accident, and at least $10,000 for property damage. Each policy must provide insurance with limits no less than these.



Other bills of interest to the Connecticut Insurance Department that died:

**Senate Bill No. 842** – *An Act Concerning Terrorism Coverage Under The Standard Fire Insurance Policy*

**Senate Bill No. 919** – *An Act Concerning the Approval Of Health Insurance Plans With Flexible Benefit Designs*

**Senate Bill No. 1088** – *An Act Concerning Medical Malpractice Insurance Rates*

**House Bill No. 6375** – *An Act Concerning Commercial Insurance Rates And Forms*